32. Continued.

Reimbursement for Provision of Immunizations. Effective for services performed on or after July 16, 1993, the single state agency or its designee makes direct payment to providers of immunizations in the Medicaid program. Participating providers are reimbursed the lesser of the billed amount or an administrative fee established by the single state agency or its designee per dose of vaccine for the provision of immunizations.

STATE Texas
DATE REC'D 8-25-93
DATE APPV'D 9-24-93
DATE EFF 7-16-93
HCFA 179 93-23
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Supersedes: None-New Page

32. Continued.

The single state agency or its designee makes direct payment for the provision of vaccines, not covered under the "regular" Medicaid Program, that are determined to be medically necessary at the lesser of the billed amount or the actual cost of the vaccine. For definitional purposes, vaccines that are covered under the regular Program are

1. Influenza and pneumococcal vaccines for high risk clients, and

2. EPSDT vaccines for childhood immunizations in the list established by the Advisory Committee on Immunization Practices (ACIP).

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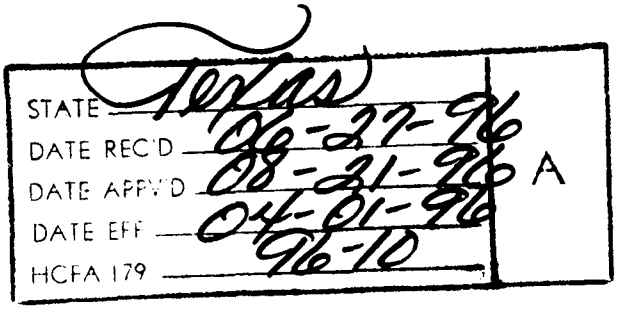
SUPERSEDES: NONE - NEW PAGE

32. Continued

15. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY. The Comprehensive Outpatient Rehabilitation Facility must be enrolled and participating in Medicare. The Texas Department of Health (department) or its designee will reimburse facilities according to Medicare reimbursement methodology.

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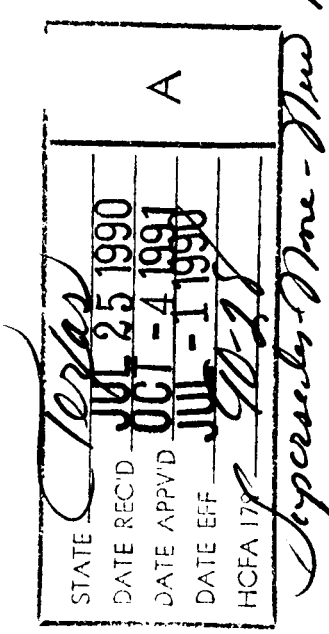
33. Case Management for Children Who are Blind or Visually Impaired

A. Reimbursement for case management services to Medicaid-enrolled blind or visually impaired children is subject to the specifications, conditions, and limitations required by the single state agency. Reimbursement will be made in accordance with United States Department of Health and Human Services Office of Management and Budget Circular A-87. For case management services to be payable, there must be one or more case management contacts per month on the client's behalf or with the client, either face-to-face or by telephone, for the purpose of enabling the client to obtain services.

The single state agency has developed a prospective, cost-based statewide uniform reimbursement system for case management services to this population. This system conforms to Medicaid cost-reimbursement and accounting principles.

The single state agency will reimburse TCB units providing case management services to Medicaid clients under individual provider agreements with the TCB units. Services will be provided through the Blind and Visually Impaired Children's Program (BVIC) within TCB. The Texas Board of Human Services will determine a reimbursement rate initially, and thereafter at least annually, for case management services. The determinations will be based on the reported costs for the provider during the provider's fiscal year. This rate is designed to reasonably reimburse the costs of an economic and efficient provider. These rates are to be prospective, cost-related and uniform statewide.




The average cost per client per month will be the basis for the prospective rate of payment for reimbursement of case management services. Rates are determined as follows:

1. Total allowable costs for the provider will be determined by an analysis of the allowable historical costs for the previous year.

2. An average allowable monthly rate will be calculated per client.

3. No cost settlement process will be used in this system.

B. Allowable costs. The following are the costs allowable in building the reimbursement rate for case management services:

1. Compensation of case management staff. Compensation may be provided only to those staff who provide case management services directly to the clients or who support the work of the staff of the case management unit in the normal conduct of operations relating to case management services. Examples

Case Management for Children Who are Blind or Visually Impaired (cont'd)

of staff include the case manager, case manager supervisors, case management unit administrator, accountant or bookkeeper, clerical workers, janitors, and building and equipment maintenance staff. Compensation includes:

a. wages and salaries;
b. payroll taxes and insurance, including Federal Insurance Contribution Act (FICA or Social Security) contributions, unemployment compensation insurance, and
c. employee benefits. These benefits include employer-paid health, life, accident, liability, and disability insurance for employees; contributions to employee retirement funds; and deferred compensation (limited to the dollar amount the employer contributes).

2. Indirect costs. Costs incurred at levels of management above the individual case management unit are allowable only if the costs were incurred in purchase of materials, supplies, or services used by the case management unit in the conduct of normal operations. Allowable costs are limited to the allocated portion of these costs which can be documented as being related to the delivery of case management services by the case management unit.

3. Material and supplies. This category includes office supplies, housekeeping supplies, and materials and supplies for the operation, maintenance, and repair of buildings, grounds, and equipment.

4. Utilities. This category includes electricity, natural gas, fuel oil, water, waste water, garbage collection, telephone, and telegraph.

5. Building, equipment, and capital expenses. Buildings, equipment, and capital used by the case management site or in support of the case management staff, and not for personal business are allowable costs. If these costs are shared with other program operations, the portion of these costs relating directly to case management may be allowed on a pro rata basis if the proportion of use for case management is documented.

6. Depreciation and amortization expense. If the provider's accounting system does not require depreciation and amortization expenses, the provider is not required to separately determine depreciation and amortization expenses for use in the calculation of the reimbursement rate for case management. If the provider's accounting system does require depreciation and amortization expenses, the provider should use the following guidelines: Property owned by the provider entity, and improvements to owned, leased, or rented case management property that are valued at more than $500 at the time of purchase must be depreciated or amortized using

33. Case Management for Children Who Are Blind or Visually Impaired (Cont'd.)

the straight line method. The minimum usable lives to be assigned to common classes of depreciable property are:

a. buildings up to 30 years, with a minimum salvage value of 10%;

b. transportation equipment used for the transport of clients, materials and supplies, or staff providing case management services; a minimum of three years for passenger automobiles; five years for light trucks and vans; passenger automobiles, light trucks, and vans all with a minimum salvage value of 10%.

7. Provider-owned property. Property may be treated by the provider as ordinary expense when the property and improvements to the property owned, leased or rented by the provider are valued at less than $500 at the time of purchase.

8. Rental and lease expense. This category includes buildings, building equipment, transportation equipment, materials and supplies. Allowable rental or lease expense paid to a related party is limited to the actual allowable cost incurred by the related party.

9. Transportation expense. This category includes depreciation, lease, or mileage claimed at the allowable reimbursement per mile set by the state legislature for state employees.

10. Business and professional association dues. Reimbursement for business and professional association dues is limited to associations devoted primarily to the issues of case management.

11. Outside training costs. The expenses are limited to direct cost (transportation, meals, lodging, and registration fees) for training provided to personnel rendering services directly to the clients or staff of the case management unit. The training must be directly related to issues concerning case management, and it must be located within the continental United States.

C. Unallowable costs. Unallowable costs are not included in the rate base used to determine recommended rates. The following list clarifies certain expense categories of unallowable costs:

1. Any form of compensation (salaries, benefits, etc.) given to individuals who do not provide case management services

33. Case Management for Children Who Are Blind or Visually Impaired (cont'd.)

directly to clients or services in support of case management staff;

2. Personal expenses not directly related to the provision of case management services;

3. Management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services provided directly to the case management unit;

4. Advertising expenses, other than those for advertising in the yellow pages, advertising for employee recruitment, and advertising to meet any statutory or regulatory requirement;

5. Business expenses not directly related to the provision of case management services;

6. Political contributions;

7. Depreciation and amortization of unallowable costs. This category includes amounts in excess of those resulting from the straight line depreciation method, including capitalized lease expenses in excess of the actual lease payment, goodwill, or any excess above the actual value of the physical assets at the time of purchase;

8. Trade discounts of all types. This category includes returns, allowances, and refunds;

9. Donated facilities, materials, supplies, and services including the value assigned to the services of unpaid workers and volunteers;

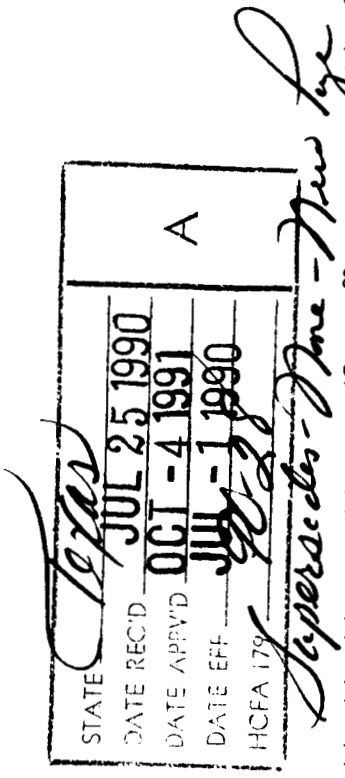
10. Dues to all types of political and social organizations, and to professional associations not directly and primarily concerned with case management services;

11. Entertainment expenses;

12. Board of director fees;

13. Fines and penalties for violations of regulations, statutes, and ordinances of all types;

14. Fund raising and promotional expenses;



23. Case Management for Children Who are Blind or Visually Impaired (cont'd)

15. Interest expenses on loans pertaining to unallowable items, and on that portion of interest paid which is reduced or offset by interest income;
16. Accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount. This category includes any form of profit sharing and the accrued liabilities of deferred compensation plans;
17. Mileage expense exceeding the current reimbursement rate set by the Texas Legislature for state employee travel;
18. Costs of purchases from a related party which exceed the original cost to the related party;
19. Out-of-state travel expenses, except for provision of case management-related services, including training and quality assurance functions;
20. Contributions to self-insurance funds which do not represent payment based on current liabilities;
21. Expenses incurred because of imprudent business practices;
22. Expenses which cannot adequately be documented;
23. Expenses not reported according to instructions; and
24. Expenses not allowable under other pertinent federal, state, or local laws or regulations.

D. Cost reporting. The Texas Commission for the Blind will submit financial and statistical information in a format designated by the single state agency, which will capture the expenses of the management unit, including salaries and benefits, administration, building and equipment, utilities, supplies, travel and indirect overhead expenses related to the case management unit.

All information submitted must be based on the accrual method of accounting, unless the governmental entity operates on a cash basis. The provider must report the financial and statistical information according to the prescribed statement of allowable and unallowable costs. Reporting should be consistent with general accepted accounting principles (GAAP). In cases where Medicaid reporting rules conflict with GAAP, Internal Revenue Service (IRS), or other authorities, Medicaid reporting rules take precedence for purposes of Medicaid auditing and rate setting.

The provider must prepare the financial and statistical information to reflect activities during the provider's fiscal year. The financial and statistical information is due after the end of the fiscal year, although an extension may be granted for good cause. The single state agency may require other information for other time periods. Failure to file an acceptable report or complete required additional information will result in a hold on provider payments until the reported information or additional information is reported. The provider must certify the accuracy of the report or additional information.

STATE Texas
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TN No. 92-26 Approval Date 8-26-92 Effective Date 7-1-92
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23. Case Management for Children Who are Blind or Visually Impaired (cont'd)

The provider must eliminate unallowable costs from the reported financial and statistical information. The single state agency or TCB excludes from the rate base any unallowable expenses included in the reported financial and statistical information and makes adjustment to reported expenses to ensure that the rate base reflects costs which are consistent with efficiency, economy, and quality of care; are necessary for the provision of case management services; and are consistent with federal and state Medicaid regulations. The single state agency notifies providers of exclusions and adjustments to reported expenses made during desk reviews and on-site audits of reported financial and statistical information. If there is doubt as to the accuracy or allowability of a significant part of the information reported, this information may be eliminated from the base rate.

The provider must allow the single state agency or its designated agents access to all records which the single state agency or its designated agents deem necessary to verify information.

The single state agency reviews reported information to ensure that all submitted financial and statistical information conforms to all applicable rules and instructions. Reports not completed according to instructions or rules are returned to the provider for proper completion.

The single state agency may perform on-site auditing each year to ensure the fiscal integrity of the case management reimbursement rate. Adjustments consistent with the results of the on-site audit will be made to the rate base in building the prospective rate of payment for the next year.

A provider who disagrees with audit disallowances may request a review of the disallowances by staff of the single state agency. The request must be made in writing.

After medical services end, the provider must maintain the recipient's medical records for five years, as stated in the provider agreement/contract. The provider must keep financial and supporting documents, statistical records, and any other records pertinent to the services for which a claim or reported financial and statistical information was submitted to the single state agency for a minimum of 3 years and 90 days after the end of the contract period or for 3 years after the end of the federal fiscal year in which services were provided. The provider must ensure that the records are accurate and sufficiently detailed to support the financial and statistical information reported. If the provider does not maintain records which support the financial and statistical information submitted, the provider will be given 90 days to correct this deficiency. A hold on payments to the provider will be made if the deficiency is not corrected with 90 days from the date the provider is notified.

34. Targeted Case Management for Individuals Receiving Services from the Department of Protective and Regulatory Services.

Rate Determination:

Title XIX cost reimbursement for Targeted Case Management for Individuals Receiving Services from the Department of Protective and Regulatory Services is a unit rate based on the monthly cost per case for documented Targeted Case Management Services.

The rate is computed by dividing (a) the Department's total quarterly cost for Medicaid targeted case management by (b) the total units of Medicaid targeted case management services provided during the quarter, meaning the number of Medicaid-eligible cases receiving documented monthly targeted case management service during the quarter.

This rate will be adjusted quarterly and applied prospectively to the claim for the subsequent quarter; i.e., the rate determined from the actual administrative costs, time study, and documented Medicaid targeted case management services during Quarter 1 will be used in preparing the claim for the services provided during Quarter 2, and so forth. The one exception to this methodology will be the first quarter of billing, where the rate will be computed based on the same quarter as the claim.

The (a) total quarterly cost for Medicaid targeted case management will be determined by application of the quarterly random moment time study to the quarterly administrative cost pool, in accordance with the most recently approved federal Cost Allocation Plan.

The (b) total units of Medicaid targeted case management service equal the total number of cases receiving documented Medicaid targeted case management service during each calendar month, i.e., those Medicaid-eligible cases in which a caseworker has documented a case management contact with or about the case during a calendar month. The provision of Medicaid targeted case management services will be recorded in a monthly Record of Contact form meeting federal Targeted Case Management documentation requirements identified in Section 4302.2 of the State Medicaid Manual (December 1991). Case narratives will provide ongoing documentation of the case manager's contacts with and on behalf of the recipient.

Rate Computation Methodology:

The rate for one unit of Medicaid targeted case management service provided to eligible cases is computed as follows: